Take away message of the project

This project can and should serve as a model for reforming other areas of health care in FYR Macedonia, such as the national emergency service. The next milestone in the reduction of perinatal mortality will be to decrease the rate to less than 10 per 1000 live births by 2005. This will require attention to the obstetric/midwifery component of perinatal health. The environment for change is ripe but funding is needed for further educational programmes and should be considered a fundamental part of the National Health Strategy.

REFERENCES

1. World Bank Health Sector Transition Project. *Former Yugoslav Republic of Macedonia*. Implementation Completion Report No. 25735, April 2003.

2. Jeffery HE, Kocova M, Tozija F, Gjorgjev D, Pop-Lazarova M, Foster K, Polverino J, Hill D. The impact of evidence-based education on a perinatal capacity-building initiative in Macedonia. *Medical Education* 2004; 38(4):435–47.

Planning for health at county level: *The Croatian experience*

Selma Sogoric

"A unique training programme Healty Counties was developed"

The war and subsequent disintegration of the former Republic of Yugoslavia during the 1990s resulted in the creation of the independent nation-states of Croatia, FYR Macedonia, Slovenia, Bosnia and Herzegovina, and Serbia and Montenegro. The recent history of armed conflict, political turmoil and severe economic change has resulted in tremendous individual and societal stresses throughout the region.[1–4]

In the case of Croatia, the transition to new forms of government and economic systems led to a deterioration of public health services.[5,6] A process of decentralisation of the health sector, which started at the beginning of 2000 mandated that local county governments assume public health planning responsibilities. These responsibilities had formerly been centralised.

This paper describes the evolution of a project aimed at strengthening local public health planning capacity at the county level of Croatia after decentralisation. Local self-government and administration in Croatia are organised into 20 counties and the City of Zagreb. Populations in the counties vary from 90,000 to 450,000, while the City of Zagreb has 800,000 inhabitants.

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The World Health Organization's Urban Health/Healthy Cities Programme in Europe provided Croatia with an early model for developing new social structures and organisational relationships to improve local public health. The initiative recognised the importance of political will and cross-sector alliances and strove to develop participatory mechanisms so that individuals, voluntary associations, and city governments in Europe could think about, understand, and make decisions together regarding local public health issues.[7–9]

Healthy counties

In the summer of 1999, directors of the Motovun Summer School of Health Promotion convened a panel of 25 Croatian public health experts to review existing public health policy and practice at the county level. The group used an assessment tool called the Local Public Health Practice Performance Measures Instrument, which had been developed by the Public Health Practice Programme Office of the US Centers for Disease Control and Prevention (CDC).[10] The Faculty from the Andrija Stampar School of Public Health adapted the instrument to fit the Croatian context and translated it into the local language. The expert panel identified the following as the weakest points in existing public health policy and

practice at the county level:

- Priority setting and policy formulation
- Strategy formulation and comprehensive planning for solving priority issues
- Coalition building among community groups and other stakeholders
- Policy assurance, an issue stemming from the lack of objectives and therefore an inability to determine whether they are achieved
- Lack of analysis of existing health resources.

In 2001, the Open Society Institute, New York financially supported and facilitated the ongoing collaboration between the Andrija Stampar School of Public Health and the CDC. The same autumn two faculty members from the Stampar School attended the CDC's Management for International Public Health course in Atlanta. Returning to Croatia they developed a unique training programme, Healthy Counties, aimed at assisting counties assess population health needs in a participatory manner, select priorities, plan for health and, ultimately, assure provision of the right type and quality of services, better tailored to population health needs.

"A 'learning-by-doing' training approach was the best tool for public health capacity building"

The programme incorporates a multidisciplinary and inter-sectoral approach, permanent consultation with community ('bottom-up' approach) and use of qualitative analysis. The curriculum was developed as a blend of recognised management tools, public health theory and practice and use of Healthy Plan-it™ material of the Sustainable Management Development Programme. The programme's main goal was to increase county-level capacities to conduct health planning and provide more effective public health services.

After two months of consultations with stakeholders in the Ministry of Health, Ministry of Labour and Social Welfare, County Governors, National Institute of Public Health and the Andrija Stampar School of Public Health, officials reached a consensus about the aims and content of the programme. A 'learning-by-doing' training approach appeared to be the best tool for public health capacity building and strengthening of collaboration between health policy stakeholders. All trainees understood from the outset that training inputs were expected to yield measurable outputs within a few months. Each county team was expected to plan and conduct assessments, and elaborate a County Health Profile and a County Health Plan.

Organisation of training

Teams from three counties completed a cycle of four 4-day workshops conducted over a period of four months. Each county team was composed of 9 to 10 representatives: at least three from the political and executive component (County Councils and Departments for Health, Labour and Social Welfare), three from the technical component (County Institute of Public Health departments, Centre for Social Welfare); and three from the community (NGOs, voluntary organisations and the media). In order to maximise the participatory nature of the workshops, the number of trainees at any given training activity was limited to 30.

Since mutual learning and exchange of experience was an important part of the process, each cohort was composed of three counties from different parts of Croatia with different levels of local governance experience. The Ministries supported the direct costs of training (training package development, teaching and staff expenses) and the counties covered trainees' lodging and travel expenses. A different county hosted each workshop and provided the training venue.

Description of curriculum

Each cohort of counties went through four days intensive training:

Workshop 1 – Assessment

County team members reviewed the core public health functions and practices, and became familiar with participatory needs assessment approaches, methods and tools. Each team developed a framework for county health needs assessment and decided on methods for involving citizens. Considerable attention was devoted to self-management and group management techniques, especially time management and team development. Homework assigned to the county teams for completion prior to the next workshop involved creating a draft version of a County Health Profile. To accomplish this, the teams had to apply one or more methods of participatory needs assessment, identify sources of information inside and outside the health sector, formulate county health status indicators, and collect appropriate data.

Workshop 2 – Healthy Plan-it™

Through application of 'Healthy Plan-it', an educational programme developed by the CDC's Sustainable Management Development Programme, county teams were guided through a health planning

process. They were first introduced to different techniques for selecting priorities among community health needs, then to problem-solving and decision-making techniques. Reaching consensus in groups that were so diverse and new to one another was a potential problem. Consequently, the trainers employed a variety of confidence building exercises and consensus techniques, which assisted in the achievement of desired team goals.

Each team selected five county health priority areas on the second day of the workshop and began to develop plans for addressing them. The teams learned how to identify and analyse problems, find their root causes and trace possibilities for solving problems inside complex, multi-organisational systems. Prior to the next workshop, the teams had to identify county 'health stakeholders' and conduct consultations on selected priorities. Following these meetings, each team revised priorities and began drafting their County Health Plans.

Workshop 3 – Policy development

This module began with an introduction to the process of building constituencies. Participants learned interpersonal communication, partnership, advocacy and negotiation skills. Collaboration with the media, public relations and social marketing were addressed. Homework assigned to the county teams required them to convene local expert panels in their respective counties to obtain advice on appropriate policies and interventions to address priority health issues.

Workshop 4 – Quality assurance

Skills developed in this module included planning change, building institutional capacity for change, and conflict recognition and resolution. Another training objective was to familiarise participants with methods for analysing the wider environment. Presentations given by representatives of the Ministry of Health, Ministry of Labour and Social Welfare and by the leader of the national health system reform project helped participants to view their county projects from a larger, national perspective. Skills like resource planning and management (both human and financial), implementation, quality assurance, monitoring and evaluation were also part of this training.

Homework for this module was to finalise the County Health Profiles and County Health Plans for public presentation six month later. The assignment required the teams to present results as well as describe the process used, including the participative assessment of health status and needs, selection of priority areas, policies and programmes to address priority health needs, implementation plans, monitoring and quality assurance mechanisms, and evaluation plans. Teams had to present their County Health Profiles and Plans locally to their own County Councils, and then nationally to other counties and ministries.

On-going follow-up

A tutorial system of guidance and monitoring was introduced after the fourth workshop to ensure that team members not lose their commitment and enthusiasm. County team coordinators met mentors monthly and follow-up workshops on county health policy development were held every three months. Alumni from the first cohort were involved in training of the second and third cohorts, providing new trainees with practical advice and guidance from recent graduates of the programme. Expert help and support to the counties was provided by the faculty on request throughout the process of developing County Health Plans.

"A centralised 'one-size-fits-all' approach is no longer sufficient"

By the beginning of September 2004, six training cohorts had completed the Healthy Counties programme (15 county teams and the city of Zagreb) and produced County Health Profiles and Health Plans with prioritised health needs and specific recommendations. Nine county councils accepted and approved their own county strategic health documents, five of these guaranteed funding for project implementation in priority areas.

Currently, training continues for a subset of those already trained. Participants consist of 'troikas,' groups of three in county leadership positions: one elected official, one professional civil servant from the county administration, and one professional from the county public health institute. The troikas liaise between their own county team, other counties and trainers from the Stampar School. During 2003/2004 troikas came together on several occasions and received additional training on evidence based public health programmes for early detection and treatment of breast cancer (Mljet, October 2003), comprehensive (medical and social) care for the elderly (Samobor, March 2004), and Total Quality Management for managers in the health sector (Uvala Scott, May 2004).

Discussion

The shift from centrally planned economies to more representative governments and market-based economies is taking place rapidly throughout South Eastern Europe. The simultaneous process of decentralisation and health sector reform has resulted in significant pressures on local governments to better plan and manage their public responsibilities. As local governments are faced with this new challenge, they are also presented with greater freedom in selecting priorities, allocating resources, and satisfying local health needs. These opportunities require increased capacity locally to identify and prioritise needs, plan, implement and evaluate interventions.

The Healthy Counties programme in Croatia has built county level capacity to assess public health needs in a participatory manner, to plan for health and assure provision of services tailored to local health needs. The programme's benefits in Croatia are extending both below and above the county level. The project serves to provide support for the more localised Healthy Cities projects, as well facilitate a paradigm shift in the national ministries' mindset that a centralised 'one-size-fits-all' approach is no longer sufficient.

The project has successfully engaged stakeholders from political, executive, and technical arenas and involved a variety of community groups (young and older people, the unemployed, farmers, islanders, urban families etc.), local politicians, and institutions in the needs assessment, prioritising and planning for health cycle.

County Health Plans are accepted politically (by County Councils), professionally and publicly. Proposed interventions for health improvements rest on local organisational and human resources and are (presently in five counties) financially supported through county budgets. With the experience gained through this programme, the Faculty of the Andrija Stampar School is extending its assistance to neighbouring countries with similar political and economic histories. The first one to try out and test nationally the training model (beginning in June 2003) is FYR Macedonia and Serbia and Montenegro will begin a similar programme in 2005.

References

1. Levett J. On the humanitarian disaster in the Balkans from a public health perspective. *The Internet Journal of Public Health Education* 1999;1:1–9.

2. Lang S. Challenge of goodness: twelve humanitarian proposals based on the experience of 1991–1995 wars in Croatia and Bosnia and Herzegovina. *Croatian Medical Journal* 1998;39:72–6.

3. Lang S. Challenge of goodness II: new humanitarian technology, developed in Croatia and Bosnia and Herzegovina in 1991–1995, and applied and evaluated in Kosovo 1999. *Croatian Medical Journal* 1999;40:438–45.

4. Beaglehole R, Bonita R. Public health at the crossroads: which way forward? *Lancet* 1998;351:590–92

5. Bozicevic I, Oreskovic S, Stevanovic R, Rodin U, Nolte E, McKee M. What is happening to the health of the Croatian population? *Croatian Medical Journal* 2001;42:601–5.

6. Lang S, Kovacic L, Sogoric S, Brborovic O. Challenge of goodness III: public health facing war. *Croatian Medical Journal* 2002;43:156–65.

7. World Health Organization Regional Office for Europe. Centre for Urban health. *Strategic Plan. Urban Health/Healthy Cities Programme (1998–2002)*. Phase III of the WHO healthy Cities project. Copenhagen: 7 June 1998.

8. World Health Organization. *City Health Profiles: How to Report on Health in Your City*. 2nd edit. Copenhagen: WHO, 1997.

9. Sogoric S. Application of the modified method of "rapid appraisal to assess community health needs" for making rapid city health profiles and city action plans for health. *Croatian Medical Journal* 1998;39:267–75.

10. Richards T B, Rogers J J, Christenson G.M et al. Assessing public health practice: Application of ten core function measures of community health in six states. *American Journal of Preventive Medicine* 1995;11(Suppl 2):36–40.